Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Births in Birthing Centers

Billing Instructions

WAC 388-533-400 & 600

July 2003

About this publication

This publication supersedes previous Licensed Midwife Billing Instructions and Numbered Memoranda 01-39 MAA and 02-27 MAA.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
July 2003

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Important Contacts

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of the inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. [WAC 388-502-0020(2)].

Where do I call for information on becoming a DSHS provider; submit a provider change of address or ownership; or to ask questions about the status of a provider application?

Call the toll-free line:
(866) 545-0544

Where do I send my claim?

Division of Program Support
PO Box 9248
Olympia, WA 98507-9248

Where can I find MAA's billing instructions and numbered memoranda?

Go to MAA's website:
http://maa.dshs.wa.gov/RBRVS/rbrvs.htm

Where do I write/call if I have policy questions?

Policy and Exception to Rule (ETR) Questions Only –
Births in Birthing Centers Program Manager
Division of Medical Management
Program Mgmt & Authorization Section
PO Box 45506
Olympia, WA 98504-5506
FAX (360) 586-1471

Where do I call if I have questions regarding…

Billing for births in birthing centers or for facility billings?
Provider Relations Unit
(800) 562-6188

Newborn Screenings?
Michael Glass
Department of Health
(206) 361-2890
Email: mike.glass@doh.wa.gov

Medical Information?
University of Washington
Med Con Line
(800) 326-5300

Maternity Case Management Services/ Maternity Support Services?
MAA Family Services Section
(360) 725-1655

Private insurance or third party liability, other than Healthy Options?
Coordination of Benefits Section
(800) 562-6136

Healthy Options- Managed Care exemption or disenrollment?
(800) 794-4360

Change in Healthy Options plan?
(800) 562-3022

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Definitions

This section defines terms and acronyms used in these billing instructions.

Authorization Number – A number assigned by MAA that identifies a specific request for approval for services or equipment. [WAC 388-500-0005]

Authorization Requirement – A condition of coverage and reimbursement for specific services or equipment, when required by WAC or billing instructions. See WAC 388-501-0165 for the authorization process. [WAC 388-500-0005]

Birthing Center – A specialized facility licensed as a childbirth center by the Department of Health (DOH) under chapter 246-349 WAC. [WAC 388-533-0400(1)(a)].

Birthing Center Provider – Any of the following individuals, who have a Core Provider Agreement with the Medical Assistance Administration (MAA) to deliver babies in a birthing center:

- A midwife, currently licensed in the State of Washington under chapter 18.50 RCW;
- Nurse Midwife currently licensed in the State of Washington under chapter 18.79 RCW; or
- Physician licensed in the State of Washington under chapter 18.57 or 18.71 RCW.

Bundled Services –Services that are incidental to a major procedure and are not separately reimbursable.
[WAC 388-500-0005]
Refer to WAC 388-533-0400(1)(b).

Chart - A compilation of medical records on an individual patient.

Client - An individual who has been determined eligible to receive medical or health care services under any MAA program. [WAC 388-500-0005]

Community Services Office(s) (CSO) - An office of the department's Economic Services Administration (ESA) that administers social and health services at the community level. [WAC 388-500-0005]

Consultation – The process whereby the birthing center provider, who maintains primary management responsibility for the woman's care, seeks the advice or opinion of a physician (MD/DO) on clinical issues that are patient-specific. These discussions may occur in person, by electronic communication, or by telephone. A consulting relationship may result in:

- Telephone, written or electronic mail recommendations by the consulting physician;
- Co-management of the patient by the birthing center provider and the consulting physician;
- Referral of the patient to the consulting physician for examination and/or treatment; or
- Transfer of patient's care from the birthing center provider to the consulting physician.

Core Provider Agreement – Is the basic contract between MAA and an entity providing services to eligible clients. The core provider agreement outlines and defines terms of participation in medical assistance programs. [WAC 388-500-0005]

Current Procedural Terminology (CPT™) – A description of medical procedures available from the American Medical Association of Chicago, Illinois.

CPT codes and descriptions are copyright 2002 American Medical Association. CPT is a trademark of the American Medical Association.

Department – The state Department of Social and Health Services.
[WAC 388-500-0005]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information regarding the claim associated with that report.
[WAC 388-500-0005]

Facility Fee – That portion of MAA's reimbursement that covers the hospital or birthing center charges. This does not include MAA's reimbursement for the professional fee.
[WAC 388-533-0400(1)(c)]

Global Fee – The fee MAA pays for total obstetrical care. Total obstetrical care includes all antepartum care, delivery services, and postpartum care.
[WAC 388-533-0400(1)(d)].

High-Risk Pregnancy – Any pregnancy that poses a significant risk of a poor birth outcome. [WAC 388-533-0400(1)(e)].

Internal Control Number (ICN) - A 17-digit number that appears on your Remittance and Status Report by the client's name. Each claim is assigned an ICN when it is received by MAA. The number identifies that claim throughout the claim's history.

Managed Care - A prepaid comprehensive system of coordinated medical and health care delivery including preventive, primary, specialty, and ancillary health services.
(See WAC 388-538-0500)
[WAC 388-500-0005]

Maximum Allowable - The maximum dollar amount MAA will reimburse a provider for a specific service, supply, or piece of equipment. [WAC 388-500-0005]

Medicaid - The state and federally funded Title XIX program under which medical care is provided to persons eligible for the:

- Categorically needy program; or
- Medically needy program.

[WAC 388-500-0005]

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-children's health insurance program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.
[WAC 388-500-0005]

Medical Identification (ID) Card – The document MAA uses to identify a client's eligibility for a medical program. These were formerly known as medical assistance identification (MAID) Cards.
[WAC 388-500-0005]

Medically Necessary - A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section 'course of treatment' may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Midwife – An individual possessing a valid, current license to practice midwifery in the State of Washington as provided in chapter 18.50 RCW, chapter 246-834 WAC, or an individual recognized by the Washington Nursing Care Quality Assurance Commission as a certified nurse midwife as provided in chapter 18.79 RCW, chapter 246-839 WAC. [WAC 246-329-010)]

Patient Identification Code (PIC) - An alphanumeric code assigned to each Medical Assistance client consisting of the patient's:

a) First and middle initials (*or* a dash (-) if the middle initial is not indicated);
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY);
c) First five letters of the last name; and
d) Alpha or numeric character (tiebreaker).

Professional Fee – The portion of MAA's reimbursement that covers the services that rely on the provider's professional skill or training, or the part of the reimbursement that recognizes the provider's cognitive skill. [WAC 388-533-0400(1)(f)]

Provider – Any person or organization that has a signed contract or Core Provider Agreement with DSHS to provider services to eligible clients. [WAC 388-500-0005]

Record - Dated reports supporting claims submitted to the Washington Medical Assistance Administration for medical services provided in an office, nursing facility, hospital, outpatient, emergency room, or other place of service.

Referral – The process by which the birthing center provider directs the client to a physician (*MD/DO*) for management (examination and/or treatment) of a particular problem or aspect of the client's care.

Remittance and Status Report (RA) - A report produced by the Medicaid Management Information System (MMIS), MAA's claims processing system, that provides detailed information concerning submitted claims and other financial transactions. [WAC 388-500-0005]

Revised Code of Washington (RCW) - Washington State law. [WAC 388-500-0005]

Third Party – Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client. [WAC 388-500-0005]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for the Children's Health Insurance Program (CHIP). [WAC 388-500-0005].

Usual & Customary Charge – The fee that the provider typically charges the general public for the product or service. [WAC 388-500-0005]

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

About the Program

What is the goal of the program?

The goal of the Births in Birthing Centers Program is to provide a safe alternative delivery setting to pregnant Medical Assistance clients at **low-risk** for adverse birth outcomes. This program promotes access to care by allowing low-risk women to give birth in a licensed, non-hospital setting.

When does MAA cover births in birthing centers?
[Refer to WAC 388-533-0600(1)]

MAA covers births in birthing centers when all of the following apply:

- The client meets the eligibility criteria (see Client Eligibility section, page B.1);
- The client is reasonably expected to deliver the child vaginally with a low risk of adverse birth outcome;
- The client is evaluated utilizing MAA's Risk Screening Guidelines (page C.1) and is deemed appropriate for a Birthing Center birth; and
- The client and maternity care provider choose an MAA-approved birthing center.

What are the responsibilities of the birthing center?
[Refer to WAC 388-533-0600(2)(3)]

Birthing centers who wish to provide services to MAA clients must:

- Be licensed as a childbirth center by the Department of Health (DOH) under chapter 246-349 WAC;
- Have a Core Provider Agreement with MAA;
- Be specifically approved by MAA to provide birthing center services; and
- Maintain standards of care required by DOH for licensure.

What are the responsibilities of the birthing center provider? **[Refer to WAC 388-533-0600(5)]**

To be reimbursed by MAA for services delivered to eligible MAA clients **in a birthing center**, a birthing center provider must:

- Obtain a signed Informed Consent including the criteria listed on page D.9 in advance of the birthing center birth from the client;
- Follow MAA's Risk Screening Guidelines (page C.1) and consult with and/or refer the client or infant to a physician or hospital, when medically necessary;
- Have current, written, and appropriate plans for consultation, emergency transfer and transport of client and/or infant to a hospital;
- Make appropriate referral of the newborn for screening and medically necessary follow-up care.
- Offer to send the newborn's blood sample to DOH for newborn screening tests (the parents may refuse this service). The provider must pay DOH for the cost of the tests and then bill MAA for reimbursement;
- Have a Core Provider Agreement with MAA; and
- Be licensed in the State of Washington as a:
  - ✓ Midwife under chapter 18.50 RCW; or
  - ✓ Nurse-midwife under chapter 18.79 RCW; or
  - ✓ Physician under chapter 18.57 or 18.71 RCW.

Client Eligibility

Who is eligible for full-scope maternity care and newborn delivery services? [Refer to WAC 388-533-400(2)(3)]

MAA covers full-scope maternity care and newborn delivery services for clients who present a current Medical Identification Card with one of the following identifiers:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP-CHIP	CNP-Children's Health Insurance Program
LCP-MNP	Limited Casualty Program – Medically Needy Program

Note: If the client is pregnant but her DSHS Medical ID Card does not list one of the above medical program identifiers, please refer the client to her local Community Services Office (CSO) to be evaluated for a possible change in her Medical Assistance program that would enable her to receive full-scope maternity care.

MAA Managed Care Clients

- Clients enrolled in an MAA managed care plan will have a plan indicator in the HMO column on their DSHS Medical ID Card. The managed care plan's toll free number is located on the Medical ID Card.
- Managed care enrollees must have all services arranged and provided by their primary care providers (PCP), except in the area of women's health care services. For certain services, such as maternity and gynecological care, women may go directly to a specialist in women's health without a referral from her PCP. However, the provider must be within her managed care plan's provider network.
- Please contact the managed care plan and the PCP for additional information on providers, including participating hospitals and birthing facilities.

- If the client's managed care plan does not contract with or pay for births in birthing centers or the provider is not in a managed care plan, please direct the client to call 1-800-794-4360.

Note: Primary Care Case Management (PCCM) clients will have the **PCCM** identifier in the HMO column on their DSHS Medical ID Cards. **Please make sure these clients have been referred by their PCCM prior to receiving services**. The Woman's Direct Access health care law does not apply to PCCM clients. The referral number is required on the HCFA-1500 claim form. (See page D.7, How do I bill for services provided to PCCM clients.)

To prevent billing denials, ALWAYS check the client's DSHS Medical ID Card prior to scheduling services and at the time of the service. This is to make sure proper authorization or referral is obtained from the primary care provider and/or plan.

First Steps Program Services

- First Steps services are supplemental services that include Maternity Support Services (MSS) and Maternity Case Management (MCM).

- MSS is available to all women receiving Medical Assistance coverage for their pregnancies. Contracted providers are available in every community statewide and provide assessment, education and intervention by Public Health nurses, nutritionists, and psychosocial workers. The services are also provided through two months postpartum.

- MCM is available for pregnant clients with certain high-risk conditions. Contracted MCM providers are available statewide. This service is also provided up to the child's first birthday.

- For more information about First Steps services and/or a list of contracted providers, please contact the First Steps Clearinghouse at (360) 725-1666.

Prenatal Management/ Risk Screening Guidelines

Prenatal Management

[WAC 388-533-0600(1)(d)]

- **Providers must screen their clients for high-risk factors.**

- The provider must consult with consulting physicians when appropriate. Follow MAA's Risk Screening Guidelines and Indications for Consultation and Referral.

- **To be reimbursed for CPT codes 99211 through 99215 with HCPCS modifier TH (Increased Monitoring Prenatal Management),** the client's record must contain the required documentation as listed below.

  The diagnoses listed below are suitable for management by the midwife but do require more visits to monitor the client. Documentation of more visits is required in the client's chart.

Diagnosis Code	Condition
640.03	Threatened abortion *(first trimester).* *(May be managed by the midwife without consultation with a physician.)*
643.03	Mild hyperemesis gravidarum (*May be managed by the midwife and will require more visits to monitor the client.)*
648.83	Abnormal glucose tolerance in a gestational diabetic *(If the condition is responsive to treatment (i.e., controlled by diet alone.)*

See next page for more…

The diagnoses listed below are suitable for prenatal co-management by a birthing center provider and a consulting physician. If a physician is the birthing center provider, that physician should consult with another physician as needed. These diagnoses require more frequent monitoring and MAA allows additional payment(s) to the provider. (See page D.2 for further information.) **The client's record must contain either documented consultation or actual evaluation by a consulting physician in order for the provider to be reimbursed for the following diagnosis codes:**

Diagnosis Code	Condition
642.03	Benign essential hypertension complicating pregnancy, childbirth, puerperium (controlled without medication)
642.33	Transient hypertension of pregnancy
644.03	Threatened premature labor *(after consultation and/or referral to a physician, and the midwife and physician have determined the client is stable and appropriate for close monitoring by the midwife)*
648.23	Anemia *(Hct<30 or Hgb<10) – Unresponsive to treatment*

Risk Screening Guidelines

MAA will not cover a birthing center birth for women identified with any of the following high-risk conditions:

- ✓ Previous cesarean section;
- ✓ Current alcohol and/or drug addiction or abuse;
- ✓ Significant hematological disorders/coagulopathies;
- ✓ History of deep venous thrombosis or pulmonary embolism;
- ✓ Cardiovascular disease causing functional impairment;
- ✓ Chronic hypertension;
- ✓ Significant endocrine disorders including pre-existing diabetes (type I or type II);
- ✓ Hepatic disorders including uncontrolled intrahepatic cholestasis of pregnancy and/or abnormal liver function tests;
- ✓ Isoimmunization, including evidence of Rh sensitization/platelet sensitization;
- ✓ Neurologic disorders or active seizure disorders;
- ✓ Pulmonary disease or active tuberculosis or severe asthma uncontrolled by medication;
- ✓ Renal disease;
- ✓ Collagen-vascular diseases;
- ✓ Current severe psychiatric illness;
- ✓ Cancer affecting site of delivery;
- ✓ Known multiple gestation;
- ✓ Known breech presentation in labor with delivery not imminent; or
- ✓ Other significant deviations from normal as assessed by the birthing center provider.

Smoking Cessation Counseling for Pregnant Women

[WAC 388-533-0400(21)]

The Medical Assistance Administration (MAA) reimburses eligible providers for including smoking cessation counseling as part of an antepartum care visit or a postpregnancy office visit (which must take place within two months following live birth, miscarriage, fetal death, or pregnancy termination).

Who is eligible for smoking cessation counseling?

Fee-for-service: Tobacco dependent, pregnant women covered under fee-for-service are eligible for smoking cessation counseling.

Managed Care: Tobacco dependent women who are enrolled in a managed care organization must have services arranged and referred by their primary care providers (PCP). Clients covered under a managed care organization will have a plan indicator in the HMO column on their Medical Identification card. **Do not bill MAA for Smoking Cessation Counseling as it is included in the managed care organizations' reimbursement rate.**

Who is eligible to be reimbursed for smoking cessation counseling?

MAA reimburses the following providers who include smoking cessation counseling as part of an antepartum care visit or a post-pregnancy office visit (which must take place within 2 months following live birth, miscarriage, fetal death, or pregnancy termination):

- Physicians
- Physician Assistants (PA) working under the guidance and billing under the provider number of a physician;
- Advanced Registered Nurse Practitioners (ARNP); and
- Licensed Midwives (LM), including certified nurse midwives (CNM).

What is smoking cessation counseling?

Smoking cessation counseling consists of provider information and assistance to help the client stop smoking. Smoking cessation counseling includes the following steps:

- Step 1: Asking the client about her smoking status;
- Step 2: Advising the client to stop smoking;
- Step 3: Assessing the client's willingness to set a quit date;
- Step 4: Assisting the client to stop smoking, which includes a written quit plan. If the provider considers it appropriate for the client, the "assisting" step may also include prescribing smoking cessation pharmacotherapy as needed (see page C.5); and
- Step 5: Arranging to track the progress of the client's attempt to stop smoking.

☞ **Note:** See Smoking Cessation Intervention for Pregnant Clients, page C.6. Please use this form, or provide the equivalent information, to document the smoking cessation counseling provided to the MAA client.

What is covered?

- MAA allows one smoking cessation counseling session per client, per day, per pregnancy, up to 10 sessions per client. The provider must keep written documentation in the client's file for each session. The documentation must reflect the information listed on page C.6.

- MAA covers two levels of counseling. Counseling levels are:

  ✓ Basic counseling (approximately 15 minutes) which includes Steps 1-3 above; and
  ✓ Intensive counseling (approximately 30 minutes) which includes Steps 1-5 above.

- Use the most appropriate procedure code from the following chart when billing for smoking cessation.

CPT® Code	Brief Description	Restricted to Diagnoses:
99401	Preventive counseling, indiv [approximately 15 minutes]	648.43 (antepartum) 648.44 (postpartum)
99402	Preventive counseling, indiv [approximately 30 minutes]	648.43 (antepartum) 648.44 (postpartum)

- A provider may prescribe pharmacotherapy for smoking cessation for a client when the provider considers the treatment appropriate for the client. MAA covers certain pharmacotherapy for smoking cessation as follows:

  MAA covers Zyban® only.

  - ✓ The product must be prescribed by a physician, ARNP, or physician assistant;
  - ✓ The client for whom the product is prescribed must be 18 years of age or older;
  - ✓ The pharmacy provider must obtain prior authorization from MAA when filling the prescription for pharmacotherapy; and
  - ✓ The prescribing provider must include both of the following on the client's prescription:

    - ➢ The client's estimated or actual delivery date; and
    - ➢ Indicate that the client is participating in smoking cessation counseling.

  To obtain prior authorization for Zyban®, pharmacy providers must call:

  Pharmacy Prior Authorization Section
  1-800-848-2842

Smoking Cessation Intervention for Pregnant Clients

Step 1: ASK–1 minute

- Ask the client to choose the statement that best describes her smoking status:

A. I have NEVER smoked or have smoked LESS THAN 100 cigarettes in my lifetime. ☐

B. I stopped smoking BEFORE I found out I was pregnant, and I am not smoking now. ☐

C. I stopped smoking AFTER I found out I was pregnant, and I am not smoking now. ☐

D. I smoke some now, but I have cut down on the number of cigarettes I smoke SINCE I found out I was pregnant. ☐

E. I smoke regularly now, about the same as BEFORE I found out I was pregnant. ☐

If the client stopped smoking before or after she found out she was pregnant (B or C), reinforce her decision to quit, congratulate her on success in quitting, and encourage her to stay smoke free throughout pregnancy and postpartum.

If client is still smoking (D or E), document smoking status in her medical record, and proceed to Advise, Assess, Assist, and Arrange.

Step 2: ADVISE–1 minute

- Provide clear, strong advice to quit with personalized messages about the benefits of quitting and the impact of smoking and quitting on the woman and fetus. ☐

Step 3: ASSESS-1 minute

- Assess the willingness of the client to attempt to quit within 30 days. ☐

If the client is ready to quit, proceed to Assist.
If the client is not ready, provide information to motivate the client to quit and proceed to Arrange.

Step 4: ASSIST-3 minutes +

- Suggest and encourage the use of problem-solving methods and skills for smoking cessation (eg, identify “trigger” solutions). ☐
- Provide social support as part of the treatment (e.g., “we can help you quit”). ☐
- Arrange social support in the smoker’s environment (e.g., identify “quit buddy” and smoke-free space). ☐
- Provide pregnancy-specific, self-help smoking cessation materials. ☐

Step 5: ARRANGE-1 minute +

- Assess smoking status at subsequent prenatal visits and, if client continues to smoke, encourage cessation. ☐

Data from Melvin C. Dolan Mullen P, Windsor RA, Whiteside HP, Goldenberg RL. Recommended cessation counseling for pregnant women who smoke: a review of the evidence. Tobacco Control 2000; 9:1-5

Prenatal Management/ Consultation & Referral

These definitions apply to the following tables labeled "Indications for Consultation & Referral":

Consultation - The process whereby the provider, who maintains primary management responsibility for the woman's care, seeks the advice or opinion of a physician on clinical issues that are patient specific. These discussions may occur in person, by electronic communication, or by telephone. A consulting relationship may result in:

- Telephone, written, or electronic mail recommendations by the MD/DO;
- Co-management of the patient by both the midwife and the MD/DO;
- Referral of the patient to the MD/DO for examination and/or treatment;
- Transfer of care of the patient from the midwife to the MD/DO.

Referral - The process by which the birthing center provider directs the client to a physician (MD/DO) for management (examination and/or treatment) of a particular problem or aspect of the client's care.

Transfer of Care – The process by which the birthing center provider directs the client to a physician for complete management of the client's care.

The client must meet MAA's risk screening criteria in order to be covered for a birth in a birthing center.

Indications for Consultation and Referral

MAA expects the provider to screen out high-risk pregnancy following MAA risk screening guidelines. The following conditions may require either a consultation or referral. MAA expects the provider to use his or her professional judgement in assessing and determining appropriate consultation and need for referral in case of adverse situation. If a physician is the birthing center provider, he or she should consult with another physician as needed. Referrals to ARNPs are appropriate for treatment of simple infections.

ANTEPARTUM **(Refers to the mother's care prior to the onset of labor)**	
Conditions Requiring Consultation *MAA requires physician (MD/DO) consultation and the client MAY require referral to a physician when the following conditions arise during the current pregnancy.*	**Conditions Requiring Referral** *MAA requires physician (MD/DO) consultation and referral when the following conditions arise during current pregnancy.*
• Breech at 37 weeks; • Polyhydramnios/Oligohydramnios; • Significant vaginal bleeding; • Persistent nausea and vomiting causing a weight loss of >15 lbs.; • Post-dates pregnancy (>42 completed weeks); • Fetal demise after 12 completed weeks gestation; • Significant size/dates discrepancies; • Abnormal fetal NST(non stress test); • Abnormal ultrasound findings; • Acute pyelonephritis; • Infections, whose treatment is beyond the scope of the birthing center provider; • Evidence of large uterine fibroid that may obstruct delivery or significant structural uterine abnormality; • No prenatal care prior to the third trimester; or • Other significant deviations from normal, as assessed by the birthing center provider.	• Evidence of pregnancy induced hypertension (BP > 140/90 for more than 6 hours with client at rest); • Hydatidiform mole (molar pregnancy); • Gestational diabetes not controlled by diet; • Severe anemia unresponsive to treatment (Hgb<10, Hct<28); • Known fetal anomalies or conditions affected by site of birth; • Noncompliance with the plan of care (e.g., frequent missed prenatal visits); • Documented placental abnormalities, significant abruption past the 1st trimester, or any evidence of previa in the 3rd trimester; • Rupture of membranes before the completion of 37 weeks gestation; • Positive HIV antibody test; • Documented IUGR (intrauterine growth retardation) • Primary genital herpes past the 1st trimester; or • Development of any of the high-risk conditions that are listed on page C.2.

INTRAPARTUM **(Refers to the mother's care in the birthing center any time after the onset of labor, up to and including the delivery of the placenta)**	
Conditions Requiring Consultation *MAA requires physician consultation and the client MAY require referral to a physician and/or hospital when the following maternal conditions arise intrapartum.*	**Conditions Requiring Referral** *MAA requires physician consultation and referral to a physician and/or hospital when the following conditions arise intrapartum.* ***NOTE:*** *In some intrapartum situations, due to time urgency, it may not be prudent to pause medical treatment long enough to seek physician consultation or initiate transport.*
• Prolonged rupture of membranes (>24 hours and not in active labor); or • Other significant deviations from normal as assessed by the birthing center provider.	• Labor before the completion of 37 weeks gestation, with known dates; • Abnormal presentation or lie at time of delivery, including breech; • Maternal desire for pain medication, consultation or referral; • *Persistent non-reassuring fetal heart rate; • Active genital herpes at the onset of labor; • Thick meconium stained fluid with delivery not imminent; • *Prolapse of the umbilical cord; • Sustained maternal fever; • *Maternal seizure; • Abnormal bleeding (*hemorrhage requires emergent transfer); • Hypertension with or without additional signs or symptoms of pre-eclampsia; • Prolonged failure to progress in active labor; or • *Sustained maternal vital sign instability and/or shock.

*** These conditions require emergency transport.**

POSTPARTUM **(Refers to the mother's care in the first 24 hours following the delivery of the placenta)**	
Conditions Requiring Consultation *MAA requires physician consultation and the client MAY require referral to a physician when the following maternal conditions arise postpartum.*	**Conditions Requiring Referral** *MAA requires physician consultation and referral when the following conditions arise postpartum.*
• Development of any of the applicable conditions listed under Antepartum and/or Intrapartum; • Significant maternal confusion or disorientation; or • Other significant deviations from normal as assessed by the birthing center provider.	• *Anaphylaxis or shock; • Undelivered adhered or retained placenta with or without bleeding; • *Significant hemorrhage not responsive to treatment; • *Maternal seizure; • Lacerations, if repair is beyond provider's level of expertise (3rd or 4th degree); • *Sustained maternal vital sign instability and/or shock; • Development of maternal fever, signs/symptoms of infection or sepsis; • *Acute respiratory distress; or • *Uterine prolapse or inversion.

*** These conditions require emergency transport.**

NEWBORN **(Refers to the infant's care during the first 24 hours following birth)**	
Conditions Requiring Consultation *MAA requires a pediatric physician be consulted. The client MAY require a referral to an appropriate pediatric physician when the following conditions arise in a neonate.*	**Conditions Requiring Referral** *MAA requires that a pediatric physician be consulted and a referral made when the following conditions arise in a neonate.*
• Apgar score ≤ 6 at five minutes of age; • Birth weight <2500 grams; • Abnormal jaundice; or • Other significant deviations from normal as assessed by the birthing center provider.	• Birth weight <2000 grams; • *Persistent respiratory distress; • *Persistent cardiac abnormalities or irregularities; • *Persistent central cyanosis or pallor; • Prolonged temperature instability when intervention has failed; • *Prolonged glycemic instability; • *Neonatal seizure; • Clinical evidence of prematurity (gestational age <35 weeks); • Loss of >10% of birth weight /failure to thrive; • Birth injury requiring medical attention; • Major apparent congenital anomalies; or • Jaundice prior to 24 hours.

*** These conditions require emergency transport.**

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Billing

Billing - Specific to Births in Birthing Centers

- **A prenatal assessment** (CPT code T1001 with HCPCS modifier TH) may be billed in addition to antepartum care or the global fee. MAA will reimburse one prenatal assessment, per provider, per client, per pregnancy. [Refer to WAC 388-533-0400(10)(a)]

- **Total obstetrical care** (CPT code 59400) includes:
  - ✓ Routine antepartum care in any trimester;
  - ✓ Delivery; and
  - ✓ Postpartum care.

  Bill a global obstetric procedure code if you performed all of the services and no other provider is billing for antepartum care, the delivery, or postpartum care. [Refer to WAC 388-533-0400(6)]. Providers may also bill these codes separately. If a provider provides all or part of the anetpartum care and/or postpartum care but does not perform the delivery, they must bill MAA for only those services provided using the appropriate antepartum and/or postpartum codes. In addition, if the client obtains other medical coverage or is transferred to an MAA managed care plan during her pregnancy, the provider must bill for only those services provided while the client is enrolled with MAA fee for service.

- **Routine antepartum care** - Per CPT guidelines, MAA considers routine antepartum care for a normal,uncomplicated pregnancy to consist of monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery (approximately 14 antepartum visits). See chart below for billing.

Procedure Code/ Modifier	Description	Limitations
59426	Antepartum care, 7 or more visits	Limited to one unit per client, per pregnancy.
59425	Antepartum care, 4-6 visits	Limited to one unit per client, per provider per pregnancy.
99211-99215 TH	Office visits, antepartum care 1-3 visits only, w/obstetrical service modifier	Diagnoses V22.0-V23.9 limited to 3 units; must use modifier TH with diagnoses to be reimbursed.

Note: **Do not bill** CPT codes 59425, 59426, and E&M codes 99211-99215 with normal pregnancy diagnoses in combination with each other during the same pregnancy. **Do not bill MAA for antepartum care until all antepartum services are complete.**

When an eligible client receives services from more than one provider, MAA reimburses each provider for the services furnished.
[Refer to WAC 388-533-0400(8)]

EXAMPLE: For a client being seen by both a midwife and a physician, MAA's reimbursement for the co-management of the client would be as follows:

- ✓ The physician would be paid for the consult office visits; and
- ✓ The midwife would be paid for the antepartum visits.

- **Increased monitoring for prenatal management** – Midwives or physicians who provide increased monitoring for the diagnoses listed below, may bill with the appropriate office visit CPT code 99211-99215 TH. The modifier TH must be used. It can only be billed when you exceed the CPT guidelines for routine antepartum visits (i.e., monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery). It may be billed in addition to the global fee when the CPT guidelines have been met.

Procedure Code/ Modifier	Summary of Description	Limits
99211–99215 TH	Office visits; use for increased monitoring prenatal management	Limited to diagnoses: 640.03, 642.03, 642.33, 643.03, 644.03, 648.23, 648.83. Must have – TH to pay midwives.

☞ **Note:** Licensed midwives are limited to billing for certain medical conditions that require additional monitoring under this program.

- **Labor management fee -** A labor management fee may be billed once per pregnancy by a midwife or physician who has managed a woman's intrapartum care at the birthing center, but referred the client to another provider for hospital delivery because of unanticipated medical complications. The midwife or physician may bill MAA for labor management when another provider in a hospital performs the delivery and the referral was made when the woman was in active labor. [Refer to WAC 388-533-0400(16)] Bill the following in combination with an established office visit with the TH modifier and the prolonged service procedure code with the modifier TH. See chart below.

Procedure Code/ Modifier	Summary of Description	Limits
99211-99215 TH	Office visits – labor at birthing center	Diagnoses 640–674.9; V22.0–V22.2; and V23–V23.9; must have modifier TH to be reimbursed with these diagnoses; labor management may not be billed by delivering physician.
+99354 TH **Limited to 1 unit**	Prolonged services, 1st hour	
+99355 TH **Limited to 4 units**	Prolonged services, each add'l 30 minutes	

☞ **Note:** Providers may bill MAA for labor management only when the client is transferred to a hospital; another provider delivers the baby; **and** a referral is made during active labor.

- **Department of Health Newborn Screening Tests** (HCPCS S3620) – A midwife or physician may bill MAA for reimbursement of S3620 after paying the Department of Health for the cost of the newborn screening tests for metabolic disorders. The newborn screening panel includes screens for PKU, CAH, congenital hypothyroidism, hemoglobinopathies, biotinidase deficiency, MSUD, MCADD, homocystinuria, and galactosemisa. Reimbursement includes two tests for two different dates of service. **Allowed once per newborn.** Do not bill S3620 if the baby is born in the hospital.

- **Immunizations** - Administration CPT codes 90471 and 90472 may be billed only when the materials are not received from the Department of Health. For information on Immunizations, please refer to MAA's Physician-Related Services Billing Instructions or EPSDT Billing Instructions. Go to: **http://maa.dshs.wa.gov** and click on the "Provider Publications/Fee Schedules" link.

- **Medications -** Certain medications can be billed separately and are listed on the fee schedule. Some of the medications listed in MAA's fee schedule are not billable by Licensed Midwives. By law, a licensed midwife may obtain and administer only certain medications. Drugs listed as "not billable by a licensed midwife" must be obtained at a pharmacy with a physician order. If you are unable to obtain a medication from a pharmacy and are using from your own supply, **see Section E - Expedited Prior Authorization for further information on billing.**

  ☞ **Note:** Drugs must be billed using the procedure codes listed and are reimbursed at MAA's established maximum allowable fees. Name, strength, and dosage of the drug must be documented and retained in the client's file for review.

- **Newborn assessment -** To bill for a newborn assessment (completed at the time of the birth in a birthing center), use CPT code 99432. **Limited to one per newborn.** Do not bill CPT code 99432 if the baby is born in a hospital.

Billing - Specific to Birthing Centers (Facility Fees)

Facility Fee – When billing for the facility fee, use CPT code 59409 with modifier SU. Only a facility licensed as a childbirth center by DOH and approved by MAA is eligible for a facility fee. Bill this fee only when the baby is born in the facility. The facility fee includes all room charges, equipment, supplies, anesthesia administration, and pain medication. The facility fee does not include other drugs, professional services, lab charges, ultrasound, other x-rays, blood draws, or injections.

Facility Transfer Fee – The facility may bill MAA for this fee when the mother is transferred in active labor to a hospital for delivery there. Use CPT code S4005 when billing for the facility transfer fee.

Procedure Code/ Modifier	Summary of Description	Limits
59409 SU	Delivery only code with use of provider's facility or equipment modifier.	Limited to one per client, per pregnancy.
S4005	Interim labor facility global (labor occurring but not resulting in delivery)	Limited to one per client, per pregnancy; may only be billed when client labors in the birthing center and then transfers to a hospital for delivery.

☞ **Note:** Payments for facility use are limited to only those providers who have been approved by MAA. When modifier SU is attached to the delivery code, it is used to report the use of the provider's facility or equipment only.

Billing – General to all Medical Assistance Programs

What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards for: 1) initial claims; and 2) resubmitted claims.

- **Initial Claims**

  - ✓ MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

    - ➢ The date the provider furnishes the service to the eligible client;
    - ➢ The date a final fair hearing decision is entered that impacts the particular claim;
    - ➢ The date a court orders MAA to cover the services; or
    - ➢ The date DSHS certifies a client eligible under delayed[1] certification criteria.

  - ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

    - ➢ DSHS certification of a client for a retroactive[2] period; or
    - ➢ The provider proves to MAA's satisfaction that there are extenuating circumstances.

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[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- **Resubmitted Claims**

  Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the time period listed above.

- The time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA?

Bill MAA your usual and customary fee.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's DSHS Medical ID Card. An insurance carrier's time limit for claim submissions may be different. It is your responsibility to meet MAA's and the insurance carrier's requirements relating to billing time limits, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at http://maa.dshs.wa.gov, or by calling the Coordination of Benefits Section at 1-800-562-6136.

How do I bill for services provided to PCCM clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or Primary Care Case Manager name in field 17 on the HCFA-1500 claim form; and

- Enter the MAA seven-digit identification number of the Primary Care Case Managers (PCCM) who referred the client for the service(s). If the client is enrolled in a PCCM plan and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

What documentation must be kept in the client's record?

[Refer to WAC 388-502-0020]

Specific to Births in Birthing Centers

Antepartum Care

- Initial general (Gen) history, physical examination, and prenatal lab tests.
- Gynecological (Gyn) history, including obstetrical history, physical examination, and standard lab tests. Ultrasound, if indicated.
- Subsequent Gen/Gyn history, physical and lab tests.
- Client's weight, blood pressure, fetal heart tones, fundal height, and fetal position at appropriate gestational age.
- Consultation, referrals, and reason for transferring care, if necessary.
- Health education and counseling.
- Consultation or actual evaluation by the consulting physician for any high-risk condition.
- Risk screening evaluation.

Intrapartum/Postpartum Care

- Labor, delivery, and postpartum periods.
- Maternal, fetal, and newborn well-being, including monitoring of vital signs, procedures, and lab tests.
- Any consultation referrals and reason for transferring care, if necessary.
- Initial pediatric care for newborn, including the name of the pediatric care provider, if known.
- Postpartum follow-up, including family planning.

Informed Consent

- Copy of informed consent, including all of the following:

  - ✓ Scope of maternal and infant care;
  - ✓ Description of services provided;
  - ✓ Limitations of technology and equipment in the home birth setting;
  - ✓ Authority to treat;
  - ✓ Plan for physician consultation or referral;
  - ✓ Emergency plan;
  - ✓ Informed assumption of risks; and
  - ✓ Client responsibilities.

General to all providers

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

A provider may contact MAA with questions regarding MAA's programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.
(Refer to WAC 388-502-0020[2])

Correct Coding Initiative (CCI)

As of January 2002 the Medical Assistance Administration (MAA) began evaluating and implementing Medicare's National Correct Coding Initiative (CCI). CCI changes could affect reimbursements to providers for CPT™ and HCPCS procedure codes.

CCI was created by the Centers for Medicare and Medicaid Services (CMS) to promote correct coding by physicians and providers and to ensure that appropriate payments are made for provider services. CCI coding policies are based on the following:

- The American Medical Association's (AMA) Current Procedural Terminology (CPT) manual;
- National and local policies and edits;
- Coding guidelines developed by national professional societies;
- Analysis and review of standard medical and surgical practices; and
- Review of current coding practices.

CCI coding policies do not supercede MAA's current Washington Administrative Code (WAC) regarding coverage and reimbursement policies or MAA Billing Instructions and Numbered Memoranda.

Authorization

Expedited Prior Authorization (EPA)

What is the EPA process?

MAA's EPA process is designed to eliminate the need to request authorization from MAA. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an "EPA" number when appropriate.

When do I need to create an EPA number?

Drugs that are listed as "Not billable by a Licensed Midwife" in the fee schedule can be administered by licensed midwives when ordered by a physician. For licensed midwives to be reimbursed by MAA for the administration of these drugs, the licensed midwife must meet the EPA criteria listed below.

How do I create an EPA number?

Once the EPA criteria is met, the licensed midwife must create a 9-digit EPA number.
The first six digits of the EPA number must be 870000**.**
The last 3 digits must be the EPA criteria listed below (**690**).

☞ **Note:** Licensed midwives are reminded that this EPA number is ONLY for the procedure codes listed in the fee schedule as "Not billable by a Licensed Midwife."

EPA Criteria for Drugs "Not Billable by Licensed Midwives"

Procedure Codes: 90371, J2540, S0077, J0290, J1364

690 Licensed midwife has met all of the following:

- Obtained physician or standing orders for the administration of the drug(s) listed as "not billable by a licensed midwife;"
- The physician or standing orders are located in the client's file; and
- The licensed midwife will provide a copy of the physician or standing orders to MAA upon request.

🗁**BILLING**: Enter the EPA number (**870000690**) in field 23 (Prior Authorization) on the HCFA-1500 claim form.
DO NOT HANDWRITE THE EPA NUMBER ONTO THE CLAIM. (See "Guidelines for completing the HCFA-1500 claim form.)

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Fee Schedule

Due to its licensing agreement with the American Medical Associations, MAA publishes only the official, brief CPT procedure code descriptions. To view the entire description, please refer to your current CPT book.

Use the following procedure codes when billing for Birthing Center services:

Routine Antepartum Care

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/03
T1001	TH	Nursing assessment w/obstetrical service modifier. **Limited to 1 unit per client, per pregnancy, per provider.**	$50.00
☞ **Note:** CPT codes 59425, 59426, or E&M codes 99211-99215 with normal pregnancy diagnoses V22.0-V23.9, **may not** be billed in combination during the entire pregnancy. **Do not bill MAA for antepartum care until all antepartum services are complete.**			
59426		Antepartum care, 7 or more visits. **Limited to 1 unit per client, per pregnancy, per provider.**	797.37
59425		Antepartum care, 4-6 visits. **Limited to 1 unit per client, per pregnancy, per provider.**	453.16
99211	TH	Office visits, antepartum care 1-3 visits, w/obstetrical service modifier. **99211 – 99215 limited to 3 units total, per pregnancy, per provider.** Must use modifier TH when billing.	14.00
99212	TH	Office/outpatient visit, est	24.75
99213	TH	Office/outpatient visit, est	34.50
99214	TH	Office/outpatient visit, est	54.00
99215	TH	Office/outpatient visit, est	79.00

Additional Monitoring			
Procedure Code	**Modifier**	**Brief Description**	**Maximum Allowable Fee Effective 7/1/03**
☞ **Note:** Midwives who provide increased monitoring for the diagnoses listed on page C.1 and C.2 and are seen in excess of the CPT guidelines for routine antepartum care may bill using the appropriate E&M code with modifier TH.			
99211	TH	Office/outpatient visit, est	$14.00
99212	TH	Office/outpatient visit, est	24.75
99213	TH	Office/outpatient visit, est	34.50
99214	TH	Office/outpatient visit, est	54.00
99215	TH	Office/outpatient visit, est	79.00

Delivery (Intrapartum)			
Procedure Code	**Modifier**	**Brief Description**	**Maximum Allowable Fee Effective 7/1/03**
59400		Obstetrical care [prenatal, delivery, and postpartum care]	1,930.28
59409		Obstetrical care [delivery only]	946.45
59410		Obstetrical care [delivery and postpartum only]	1,060.42

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Labor Management

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/03
☞	**Note:**	Bill only when the client labors at the birthing center and is then transferred to a hospital, another provider delivers the baby, and a referral is made during active labor. The following diagnoses must be used 640–674.9; V22.0–V22.2; and V23–V23.9 with modifier TH.	
☞	**Note:**	Labor management may not be billed by the delivering physician. Prolonged services must be billed on the same claim form as E&M codes along with modifier TH and one of the diagnoses listed above (all must be on each detail line of the claim form).	
99211	TH	Office/outpatient visit, est (Use when client labors at birthing center)	$14.00
99212	TH	Office/outpatient visit, est	24.75
99213	TH	Office/outpatient visit, est	34.50
99214	TH	Office/outpatient visit, est	54.00
99215	TH	Office/outpatient visit, est	79.00
+ 99354	TH	Prolonged services, 1st hour. **Limited to 1 unit.**	74.39
+ 99355	TH	Prolonged services, each add'l 30 minutes. **Limited to 4 units.**	69.39

(+) = Add-on code

Postpartum

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/03
59430		Care after delivery [postpartum only]	155.01

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Other			
Procedure Code	**Modifier**	**Brief Description**	**Maximum Allowable Fee Effective 7/1/03**
59020		Fetal contract stress test	$36.63
59020	TC	Fetal contract stress test	13.42
59020	26	Fetal contract stress test	23.21
59025		Fetal non-stress test	48.78
59025	TC	Fetal non-stress test	11.40
59025	26	Fetal non-stress test	37.84
36415		Drawing blood	2.45
84703		Chorionic gonadotropin assay	8.50
85013		Hematocrit	2.68
85014		Hematocrit	2.68
A4266		Diaphragm	45.00
A4261		Cervical cap for contraceptive use	47.00
57170		Fitting of diaphragm/cap	53.92
90782		Injection, sc/im	2.50
90371		Hep b ig, im **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	143.18
J2790		Rh immune globulin	90.82
J2540		Injection, penicillin G potassium, up to 600,000 units. **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	0.26
S0077		Injection, clindamycin phosphate, 300 mg. **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	Acquisition Cost Include invoice

Other (cont.)			
Procedure Code	**Modifier**	**Brief Description**	**Maximum Allowable Fee Effective 7/1/03**
J0290		Injection, ampicillin, sodium, up to 500mg. (use separate line for each 500 mg used) **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	$1.49
J1364		Injection, erythromycin lactobionate, per 500 mg. (use separate line for each 500 mg used) **[Not billable by a Licensed Midwife. For exception, see Section E - Expedited Prior Authorization.]**	3.18
J7050		Infusion, normal saline solution, 250cc	2.44
S5011		5% dextrose in lactated ringer's, 1000 ml.	Acquisition Cost Include invoice
J7120		Ringers lactate infusion, up to 1000cc	11.27
J2210		Injection methylergonovine maleate, up to 0.2mg	3.51
J3475		Injection, magnesium sulfate, per 500 mg	0.26
J2590		Injection, oxytocin	1.16
J0170		Injection adrenalin, epinephrine, up to 1ml ampule	2.15
J3430		Injection, phytonadione (Vitamin K) per 1 mg.	2.19
90708		Measles-rubella vaccine, sc	21.81
90471		Immunization admin	5.00
90472		Immunization admin, each add **[List separately in addition to code for primary procedure.]**	3.00

Other (cont.)			
Procedure Code	**Modifier**	**Brief Description**	**Maximum Allowable Fee Effective 7/1/03**
S3620		Newborn metabolic screening panel, include test kit, postage and the laboratory tests specified by the state for inclusion in this panel. **[Department of Health newborn screening tests for metabolic disorders. Includes 2 tests on separate dates; one per newborn.]**	$64.40
99401		Preventive counseling, indiv [approximately 15 minutes] Restricted to diagnoses: 648.43 (antepartum) and 648.44 (postpartum) [**For Smoking Cessation only]**	25.48
99402		Preventive counseling, indiv [approximately 30 minutes] Restricted to diagnoses: 648.43 (antepartum) and 648.44 (postpartum) [**For Smoking Cessation only]**	42.54
99432		Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conference(s) with parent(s). **Limited to one per newborn. Do not bill MAA if baby is born in a hospital.**	69.31
99440		Newborn resuscitation: provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output	89.64
92950		Cardiopulmonary resuscitation (eg, in cardiac arrest)	112.39

Fee Schedule for Facility Fee Payment

Facility fee payment for Birthing Centers licensed by the Department of Health that have a Core Provider Agreement with MAA.

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee Effective 7/1/03
59409	SU	Delivery only code with use of provider's facility or equipment modifier. **Limited to one unit per client, per pregnancy.** Facility fee includes all room charges, equipment, supplies, anesthesia administration, and pain medication.	$733.16
S4005		Interim labor facility global (labor occurring but not resulting in delivery). **Limited to one per client, per pregnancy.** May only be billed when client labors in the birthing center and then transfers to a hospital for delivery.	366.68

Note: Payments for facility use are limited to only those providers who have been approved by MAA. When modifier SU is attached to the delivery code, it is used to report the use of the provider's facility or equipment only.

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How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

Guidelines/Instructions:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

- **Do not use red ink pens, highlighters, "post-it notes," stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not faded or too light!**

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

Field Description/Instructions

1A. **Insured's ID No.**: Required. Enter the Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the client's DSHS Medical ID Card. This number consists of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.
- Tom O'Malley's PIC should look like this: TC020652O'MALA (**Note:** Always use the exact PIC as it appears on the client's Medical ID Card regardless of whether it follows the above examples.)

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the Medicaid client.

Field Description/Instructions

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or program name (e.g., the insured's health maintenance organization, and private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, Healthy Options, First Steps, Medicare, Public Assistance, etc., are inappropriate entries for this

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24.* ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4.* Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payer of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3.*

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.

17. **Name of Referring Physician or Other Source**: When applicable, enter the primary physician.

17a. **ID Number of Referring Physician**: When applicable, enter the 7-digit MAA-assigned primary physician number.

19. When applicable. When billing for baby using the mother's PIC, **enter "B."**

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the *Remittance and Status Report*.)

23. **Prior Authorization Number**: To be reimbursed for drugs listed in fee schedule as "Not billable by a Licensed Midwife**," enter the EPA number 870000690**. (See Section E for further information.)

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., July 05, 2003 = 070503).

24B. **Place of Service**: Required.

Prior to dates of service October 1, 2003, use the following Place of Service codes:

3 Office
9 Birthing Center

On and after October 1, 2003, use the following Place of Service codes:

11 Office
25 Birthing Center

24C. **Type of Service**: Required prior to October 1, 2003, dates of service. Enter a 3 for all services billed.

For claims with dates of service on and after October 1, 2003, this field IS NOT A REQUIRED FIELD.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate Current Procedural Terminology (CPT) or HCFA Common Procedure Coding System (HCPCS), or state-unique procedure code for the services being billed.

Modifier: When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. Enter the total number of units for each line. These figures must be whole units.

25. **Federal Tax ID Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your *Remittance and Status Report* under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

32. **Name and Address of Facility Where Services Were Rendered**: Enter the name of the birthing center.

33. **Physician's, Supplier's Billing Name, Address, Zip Code And Phone #**: Required. Put the *Name, Address,* and *Phone #* on all claim forms.

P.I.N.: This is the seven-digit number assigned to you by MAA for:

A) An individual practitioner (solo practice); **or**

B) An identification number for individuals only when they are part of a group practice (see below).

Group: This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number.

NOTE: Certain group numbers may require a PIN number, in addition to the group number, in order to identify the performing provider.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

PROVIDERS IN BIRTHING CENTERS

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): MK070174SMITHA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH MARY K

3. PATIENT'S BIRTH DATE MM DD YY: 07 01 74 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1800 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): (360) 111-2222

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V22.2
2. 650.
3. 643.03
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	10	01	02	10	01	02	3	3	T1001	TH	1	5000	1				
2	05	01	03	05	01	03	9	3	59400		2	178700	1				
3	11	01	02	11	01	02	3	3	99211	TH	3	2961	1				
4																	
5																	
6																	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 186661

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 186661

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

ABC BIRTH CENTER
103 MAIN STREET
ANYTOWN WA 98300

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

MARY SMITH LM 105 STATE STREET
ANYTOWN WA 98000 (360) 555-1111

PIN# GRP# 7000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

BIRTHING CENTERS - FACILITY FEE PAYMENT

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): MK070174SMITHA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH MARY K

3. PATIENT'S BIRTH DATE MM DD YY: 07 01 74 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1800 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): (360) 111-2222

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

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15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 650.
2. V30.2
3. 643.03
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07	01	03	07	01	03	9	3	59409	SU	650	70400	1				
2 05	01	03	05	01	03	9	3	59400		2		1				
3 11	01	02	11	01	02	3	3	99211	TH	3		1				
4																
5																
6																

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 70400

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 70400

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

ABC Birth Center
103 MAIN STREET
ANYTOWN WA 98300

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

ABC BIRTH CENTER 103 MAIN STREET
ANYTOWN WA 98300

PIN#

GRP# 7090000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

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